NECA-IBEW Welfare Trust Fund
Summary Plan Description (SPD) and
Plan Document

SCHEDULES OF BENEFITS

Revised September 2025

Base Plan for Active Employees

Schedule of Benefits for Active Employees and Their Eligible Dependents with Base Plan Coverage

Effective August 1, 2025

DEATH BENEFITS – EMPLOYEE ONLY	
Active Employees' Death Benefit	$20,000
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – EMPLOYEE ONLY	
Active Employees' Accidental Death and Dismemberment Benefit	$20,000
WEEKLY INCOME BENEFIT	
Weekly Benefits • First 6 Weeks • 7th through 12th Week • 13th through 26th Week	 $390 $520 $650
Maximum Number of Weeks Payable	26 Weeks
Benefits begin: • Disability due to Injury • Disability due to Sickness	 1st day of Disability 8th day of Disability
• If Disability due to Sickness lasts more than 8 weeks, the Plan will retroactively pay benefits for the first week of Disability. • Treatment resulting from an Accident must occur within 14 days of the Accident. • Disabilities lasting longer than 13 weeks are subject to large case management review.	
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Benefits are payable for the Allowable Charges for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after the individual meets the Calendar Year Deductible.	
Preventive Care Benefits	100% coverage – no Cost Sharing For a basic listing of covered preventive care services, visit www.healthcare.gov/coverage/preventive-care-benefits Visit www.neca-ibew.org or contact the Fund Office for further details on Preventive Care Benefits.
Calendar Year Maximum (applies to Covered Expenses)	Unlimited
Calendar Year Deductible • Individual Deductible • Family Maximum Deductible	 $600 $1,800

Coinsurance • PPO Provider • Non-PPO Provider	 90% of first $19,000 of Individual Allowable Charges, 100% thereafter 70% of first $6,334 of Individual Allowable Charges, 100% thereafter
Calendar Year Coinsurance Out-of-Pocket Maximum, after Deductible • Individual • Family Maximum	 $1,900 $3,800
Non-Accident Emergency Room Deductible (does not apply to Deductible or Out-of-Pocket Maximum)	$60 per visit after first two visits per Calendar Year
Physician Office Visits Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	$15 per visit
Specialist Office Visits Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	$15 per visit
Chiropractic Treatment • Coinsurance paid by Plan • Calendar Year Maximum • Calendar Year Out-of-Pocket Maximum	 50% 48 visits None
Temporomandibular Joint Dysfunction (TMJ) • Coinsurance Plan Pays • Lifetime Maximum (The TMJ lifetime maximum applies to appliances, manipulation, and other non-surgical, non-diagnostic charges for Participants and Dependents age 18 and older. There is no lifetime maximum for Dependent children up to age 18.)	 75% $3,500
Testosterone Replacement Therapy Calendar Year Maximum (requires verification of Medical Necessity and lab results showing deficiency)	$2,500
Growth Hormone Therapy • Lifetime Maximum (subject to Medical Necessity) • Lifetime Maximum for Dependent Child (subject to Medical Necessity)	 No maximum No maximum
Physical/Massage/Speech/Occupational/Acupuncture Therapy • Physical/Massage/Acupuncture Therapy Calendar Year Maximum • Speech Therapy Calendar Year Maximum • Occupational Therapy Calendar Year Maximum (Limits are for Eligible individuals age six and older; benefits for Dependents younger than age six are unlimited as long as the Dependent is making ongoing therapeutic progress.)	 48 visits 48 visits 48 visits

Hearing Aid Benefit • For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) • EPIC Hearing Service Plan	 $1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020) Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries
Calendar Year Medical Out-of-Pocket Maximum ("MOOP") (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Prescription Drug Expenses.**	 $4,600 $9,200
ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when an out-of-network non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.	
Organ Transplant Calendar Year Deductible Individual Deductible	 Major Medical Deductible of $600
Organ Transplant Coinsurance • COE Facility • PPO Non-COE Facility • Non-PPO Non-COE Facility	 90% of first $19,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges, Medical Out-of-Pocket Maximum applies 50% of Allowable Charges
Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible • COE Facility • Non-COE Facility	 Medical Out-of-Pocket Maximum of $4,600 per individual, $9,200 per family No Out-of-Pocket Maximum
Organ Transplant Immunosuppressive Medications	See "Specialty Medications" below.
Organ Procurement Benefit	$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities Not subject to Deductible
Organ Transplant Transportation/Lodging	$10,000
BEHAVIORAL HEALTH BENEFITS	
Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).	

EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 EAP Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Prescription Drug Deductible per Calendar Year per Person	$60
Participating Retail Pharmacy Copayment up to a 34-day supply:[1] • Generic Prescription • Brand Name Prescription	 $15 $20[2]
Non-Participating Retail Pharmacy Coinsurance	50%
Mail-Order Program Copayment up to a 90-day supply: • Generic Prescription • Brand Name Prescription	 $25 $35[2]
Specialty Medications[3]	10% Coinsurance, up to a maximum of $125 per prescription fill for a 34-day supply[4]
GLP-1 Medications for Obesity	50% Coinsurance; lifetime limit of 18 months; Prescription Drug Deductible does not apply
Calendar Year Prescription Drug Out-of-Pocket Maximum ("MOOP") (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Medical Expenses.**	 $4,600 $9,200

[1] For maintenance medications, only the original prescription and first two refills of maintenance medication may be purchased from the Retail Network. The third refill and all subsequent refills must be filled by the Mail-Order Program.

[2] Plus difference in cost between the generic and brand name prescriptions when a generic is available.

[3] Specialty medications that are included on the Select Drugs and Products List and are administered by a health care provider in a hospital, clinic, or facility, and those self-administered, are subject to Pre-certification for Medical Necessity and participation in the Select Drugs and Products Program. All Covered Persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to Prior Authorization, step therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain Medical Necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.

[4] Covered Persons who were receiving specialty medications prior to January 1, 2013 will continue to pay the Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable.

DENTAL BENEFITS*	
Maximum Benefit per Person age 19 and older	$1,500 per Calendar Year
Maximum Benefit per Person under age 19	Unlimited

Coinsurance • Type I • Type II • Type III • Orthodontia	 90% of Allowable Charges 85% of Allowable Charges 50% of Allowable Charges 50% of Allowable Charges up to a lifetime maximum orthodontia benefit of $2,000
VISION BENEFITS*	
Coverage for each Covered Person age 19 and older includes:	Calendar year eye exam, lenses, frames, and contact lenses
Maximum Benefit per Calendar Year for each Covered Person age 19 and older	$400 maximum (up to $500 when using an EyeMed network provider)
Coverage for each Covered Person under age 19 includes:	Eye exams and materials related to vision correction, including any one of the following options: a. Frames and lenses b. Contact lenses c. One set of frames and a one-year supply of contact lenses
Maximum Benefit per Calendar Year for each Covered Person under age 19	No dollar maximum
EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

* If you wish, you may elect to cease coverage for dental benefits and/or vision benefits under the Plan for yourself or your Dependents. If you previously elected to cease coverage for dental and/or vision benefits under the Plan, you may reinstate coverage. If you wish to cease or reinstate coverage, you must notify the Fund Office in writing. See your SPD/Plan Document for more information.

Alternative Plan for Active Employees

Schedule of Benefits for Active Employees and Their Eligible Dependents with Alternative Plan Coverage

Effective August 1, 2025

NOTE: This Schedule of Benefits also reflects the benefits for the Employee and Dependent Children Only coverage tier, which does not cover Spouses.

DEATH BENEFITS – EMPLOYEE ONLY	
Active Employees' Death Benefit	$10,000
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – EMPLOYEE ONLY	
Active Employees' Accidental Death and Dismemberment Benefit	$10,000
WEEKLY INCOME BENEFIT	
Weekly Benefits • First 6 Weeks • 7th through 12th Week • 13th through 26th Week	 $390 $520 $650
Maximum Number of Weeks Payable	26 Weeks
Benefits begin: • Disability due to Injury • Disability due to Sickness	 1st day of Disability 8th day of Disability
• If Disability due to Sickness lasts more than 8 weeks, the Plan will retroactively pay benefits for the first week of Disability. • Treatment resulting from an Accident must occur within 14 days of the Accident. • Disabilities lasting longer than 13 weeks are subject to large case management review.	
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Benefits are payable for the Allowable Charges for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after the individual meets the Calendar Year Deductible.	
Preventive Care Benefits	100% coverage – no Cost Sharing For a basic listing of covered preventive care services, visit www.healthcare.gov/coverage/preventive-care-benefits Visit www.neca-ibew.org or contact the Fund Office for further details on Preventive Care Benefits.
Calendar Year Maximum (applies to Covered Expenses)	Unlimited
Calendar Year Deductible • Individual Deductible • Family Maximum Deductible	 $1,000 $3,000

Coinsurance • PPO Provider • Non-PPO Provider	 80% of first $15,000 of Individual Allowable Charges, 100% thereafter 60% of first $7,500 of Individual Allowable Charges, 100% thereafter
Calendar Year Coinsurance Out-of-Pocket Maximum, after Deductible • Individual • Family Maximum	 $3,000 $6,000
Non-Accident Emergency Room Deductible (does not apply to Deductible or Out-of-Pocket Maximum)	$50 per visit after first two visits per Calendar Year
Physician Office Visits Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	$20 per visit
Specialist Office Visits Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	$40 per visit
Chiropractic Treatment • Coinsurance paid by Plan • Calendar Year Maximum • Calendar Year Out-of-Pocket Maximum	 50% 48 visits None
Temporomandibular Joint Dysfunction (TMJ) • Coinsurance Plan Pays • Lifetime Maximum (The TMJ lifetime maximum applies to appliances, manipulation, and other non-surgical, non-diagnostic charges for Participants and Dependents age 18 and older. There is no lifetime maximum for Dependent children up to age 18.)	 75% $3,500
Testosterone Replacement Therapy Calendar Year Maximum (requires verification of Medical Necessity and lab results showing deficiency)	$2,500
Growth Hormone Therapy • Lifetime Maximum (subject to Medical Necessity) • Lifetime Maximum for Dependent Child (subject to Medical Necessity)	 No maximum No maximum
Physical/Massage/Speech/Occupational/Acupuncture Therapy • Physical/Massage/Acupuncture Therapy Calendar Year Maximum • Speech Therapy Calendar Year Maximum • Occupational Therapy Calendar Year Maximum (Limits are for Eligible individuals age six and older; benefits for Dependents younger than age six are unlimited as long as the Dependent is making ongoing therapeutic progress.)	 48 visits 48 visits 48 visits

Hearing Aid Benefit • For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) • EPIC Hearing Service Plan	 $1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020) Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries
Calendar Year Medical Out-of-Pocket Maximum ("MOOP") (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Prescription Drug Expenses.**	 $4,600 $9,200
ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when an out-of-network non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.	
Organ Transplant Calendar Year Deductible Individual Deductible	 Major Medical Deductible of $600
Organ Transplant Coinsurance • COE Facility • PPO Non-COE Facility • Non-PPO Non-COE Facility	 80% of first $15,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges, Medical Out-of-Pocket Maximum applies 50% of Allowable Charges
Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible • COE Facility • Non-COE Facility	 Medical Out-of-Pocket Maximum of $4,600 per individual, $9,200 per family No Out-of-Pocket Maximum
Organ Transplant Immunosuppressive Medications	See "Specialty Medications" below.
Organ Procurement Benefit	$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities Not subject to Deductible
Organ Transplant Transportation/Lodging	$10,000
BEHAVIORAL HEALTH BENEFITS	
Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).	

EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 EAP Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Prescription Drug Deductible per Calendar Year per Person	None
Participating Retail Pharmacy Copayment up to a 34-day supply:[1] • Generic Prescription • Preferred Brand Name Prescription • Non-Preferred Brand Name Prescription	 $25 $40[2] $50[2]
Non-Participating Retail Pharmacy Coinsurance	50%
Mail-Order Program Copayment up to a 90-day supply: • Generic Prescription • Preferred Brand Name Prescription • Non-Preferred Brand Name Prescription	 $50 $80[2] $100[2]
Specialty Medications[3]	10% Coinsurance, up to a maximum of $125 per prescription fill for a 34-day supply[4]
GLP-1 Medications for Obesity	50% Coinsurance; lifetime limit of 18 months; Prescription Drug Deductible does not apply
Calendar Year Prescription Drug Out-of-Pocket Maximum ("MOOP") (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Medical Expenses.**	 $4,600 $9,200

[1] For maintenance medications, only the original prescription and first two refills of maintenance medication may be purchased from the Retail Network. The third refill and all subsequent refills must be filled by the Mail-Order Program.

[2] Plus difference in cost between the generic and brand name prescriptions when a generic is available.

[3] Specialty medications that are included on the Select Drugs and Products List and are administered by a health care provider in a hospital, clinic, or facility, and those self-administered, are subject to Pre-certification for Medical Necessity and participation in the Select Drugs and Products Program. All Covered Persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to Prior Authorization, step therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain Medical Necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.

[4] Covered Persons who were receiving specialty medications prior to January 1, 2013 will continue to pay the Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable.

EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

Base Plan for Retired Employees Under Age 65

Schedule of Benefits for Retired Employees and Eligible Dependents Under Age 65 with Base Plan Coverage

Effective August 1, 2025

DEATH BENEFITS – RETIRED EMPLOYEE ONLY	
Retired Employees' Death Benefit	$5,000
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Benefits are payable for the Allowable Charges for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after the individual meets the Calendar Year Deductible.	
Preventive Care Benefits	100% coverage – no Cost Sharing For a basic listing of covered preventive care services, visit www.healthcare.gov/coverage/preventive-care-benefits Visit www.neca-ibew.org or contact the Fund Office for further details on Preventive Care Benefits.
Calendar Year Maximum (applies to Covered Expenses)	Unlimited
Calendar Year Deductible • Individual Deductible • Family Maximum Deductible	 $600 $1,800
Coinsurance • PPO Provider • Non-PPO Provider	 90% of first $19,000 of Individual Allowable Charges, 100% thereafter 70% of first $6,334 of Individual Allowable Charges, 100% thereafter
Calendar Year Coinsurance Out-of-Pocket Maximum, after Deductible • Individual • Family Maximum	 $1,900 $3,800
Non-Accident Emergency Room Deductible (does not apply to Deductible or Out-of-Pocket Maximum)	$60 per visit after first two visits per Calendar Year
Physician Office Visits Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	$15 per visit
Specialist Office Visits Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	$15 per visit

Chiropractic Treatment • Coinsurance paid by Plan • Calendar Year Maximum • Calendar Year Out-of-Pocket Maximum	 50% 48 visits None
Temporomandibular Joint Dysfunction (TMJ) • Coinsurance Plan Pays • Lifetime Maximum (The TMJ lifetime maximum applies to appliances, manipulation, and other non-surgical, non-diagnostic charges for Participants and Dependents age 18 and older. There is no lifetime maximum for Dependent children up to age 18.)	 75% $3,500
Testosterone Replacement Therapy Calendar Year Maximum (requires verification of Medical Necessity and lab results showing deficiency)	 $2,500
Growth Hormone Therapy • Lifetime Maximum (subject to Medical Necessity) • Lifetime Maximum for Dependent Child (subject to Medical Necessity)	 No maximum No maximum
Physical/Massage/Speech/Occupational Therapy • Physical/Massage/Acupuncture Therapy Calendar Year Maximum • Speech Therapy Calendar Year Maximum • Occupational Therapy Calendar Year Maximum (Limits are for Eligible individuals age six and older; benefits for Dependents younger than age six are unlimited as long as the Dependent is making ongoing therapeutic progress.)	 48 visits 48 visits 48 visits
Hearing Aid Benefit • For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) • EPIC Hearing Service Plan	 $1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020) Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries
Calendar Year Medical Out-of-Pocket Maximum ("MOOP") (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Prescription Drug Expenses.**	 $4,600 $9,200

ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when an out-of-network non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.	
Organ Transplant Calendar Year Deductible Individual Deductible	 Major Medical Deductible of $600
Organ Transplant Coinsurance • COE Facility • PPO Non-COE Facility • Non-PPO Non-COE Facility	 90% of first $19,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges, Medical Out-of-Pocket Maximum applies 50% of Allowable Charges
Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible • COE Facility • Non-COE Facility	 Medical Out-of-Pocket Maximum of $4,600 per individual, $9,200 per family No Out-of-Pocket Maximum
Organ Transplant Immunosuppressive Medications	See “Specialty Medications” below.
Organ Procurement Benefit	$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities Not subject to Deductible
Organ Transplant Transportation/Lodging	$10,000
BEHAVIORAL HEALTH BENEFITS	
Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).	
EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 EAP Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Prescription Drug Deductible per Calendar Year per Person	$60
Participating Retail Pharmacy Copayment up to a 34-day supply:[1] • Generic Prescription • Brand Name Prescription	 $15 $20[2]
Non-Participating Retail Pharmacy Coinsurance	50%
Mail-Order Program Copayment up to a 90-day supply: • Generic Prescription • Brand Name Prescription	 $25 $35[2]

Specialty Medications[3]	10% Coinsurance, up to a maximum of $125 per prescription fill for a 34-day supply[4]
GLP-1 Medications for Obesity	50% Coinsurance; lifetime limit of 18 months; Prescription Drug Deductible does not apply
Calendar Year Prescription Drug Out-of-Pocket Maximum ("MOOP") (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Medical Expenses.**	 $4,600 $9,200

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[2] Plus difference in cost between the generic and brand name prescriptions when a generic is available.

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[4] Covered Persons who were receiving specialty medications prior to January 1, 2013 will continue to pay the Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable.

DENTAL BENEFITS*	
Maximum Benefit per Person age 19 and older	$1,500 per Calendar Year
Maximum Benefit per Person under age 19	Unlimited
Coinsurance • Type I • Type II • Type III • Orthodontia	 90% of Allowable Charges 85% of Allowable Charges 50% of Allowable Charges 50% of Allowable Charges up to a lifetime maximum orthodontia benefit of $2,000

VISION BENEFITS*	
Coverage for each Covered Person age 19 and older includes:	Calendar year eye exam, lenses, frames, and contact lenses
Maximum Benefit per Calendar Year for each Covered Person age 19 and older	$400 maximum (up to $500 when using an EyeMed network provider)
Coverage for each Covered Person under age 19 includes:	Eye exams and materials related to vision correction, including any one of the following options: a. Frames and lenses b. Contact lenses c. One set of frames and a one-year supply of contact lenses

Maximum Benefit per Calendar Year for each Covered Person under age 19	No dollar maximum
EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

* If you wish, you may elect to cease coverage for dental benefits and/or vision benefits under the Plan for yourself or your Dependents. If you previously elected to cease coverage for dental and/or vision benefits under the Plan, you may reinstate coverage. If you wish to cease or reinstate coverage, you must notify the Fund Office in writing. See your SPD/Plan Document for more information.

Alternative Plan for Retired Employees Under Age 65

Schedule of Benefits for Retired Employees Under Age 65 and Their Eligible Dependents with Alternative Plan Coverage

Effective August 1, 2025

DEATH BENEFITS – RETIRED EMPLOYEE ONLY	
Retired Employees' Death Benefit	$5,000
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Benefits are payable for the Allowable Charges for Covered Medical Expenses that are Medically Necessary for the treatment of a Sickness or Injury. Comprehensive Major Medical Benefits are only paid after the individual meets the Calendar Year Deductible.	
Preventive Care Benefits	100% coverage – no Cost Sharing For a basic listing of covered preventive care services, visit www.healthcare.gov/coverage/preventive-care-benefits Visit www.neca-ibew.org or contact the Fund Office for further details on Preventive Care Benefits.
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Calendar Year Deductible • Individual Deductible • Family Maximum Deductible	 $1,000 $3,000
Coinsurance • PPO Provider • Non-PPO Provider	 80% of first $15,000 of Individual Allowable Charges, 100% thereafter 60% of first $7,500 of Individual Allowable Charges, 100% thereafter
Calendar Year Coinsurance Out-of-Pocket Maximum, after Deductible • Individual • Family Maximum	 $3,000 $6,000
Non-Accident Emergency Room Deductible (does not apply to Deductible or Out-of-Pocket Maximum)	$50 per visit after first two visits per Calendar Year
Physician Office Visits Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	$20 per visit
Specialist Office Visits Copayment (does not apply to Deductible or Out-of-Pocket Maximum)	$40 per visit

Chiropractic Treatment • Coinsurance paid by Plan • Calendar Year Maximum • Calendar Year Out-of-Pocket Maximum	 50% 48 visits None
Temporomandibular Joint Dysfunction (TMJ) • Coinsurance Plan Pays • Lifetime Maximum (The TMJ lifetime maximum applies to appliances, manipulation, and other non-surgical, non-diagnostic charges for Participants and Dependents age 18 and older. There is no lifetime maximum for Dependent children up to age 18.)	 75% $3,500
Testosterone Replacement Therapy Calendar Year Maximum (requires verification of Medical Necessity and lab results showing deficiency)	 $2,500
Growth Hormone Therapy • Lifetime Maximum (subject to Medical Necessity) • Lifetime Maximum for Dependent Child (subject to Medical Necessity)	 No maximum No maximum
Physical/Massage/Speech/Occupational/Acupuncture Therapy • Physical/Massage/Acupuncture Therapy Calendar Year Maximum • Speech Therapy Calendar Year Maximum • Occupational Therapy Calendar Year Maximum (Limits are for Eligible individuals age six and older; benefits for Dependents younger than age six are unlimited as long as the Dependent is making ongoing therapeutic progress.)	 48 visits 48 visits 48 visits
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Calendar Year Medical Out-of-Pocket Maximum ("MOOP") (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Prescription Drug Expenses.**	 $4,600 $9,200

ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when an out-of-network non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.	
Organ Transplant Calendar Year Deductible Individual Deductible	Major Medical Deductible of $600
Organ Transplant Coinsurance • COE Facility • PPO Non-COE Facility • Non-PPO Non-COE Facility	 80% of first $15,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges, Medical Out-of-Pocket Maximum applies 50% of Allowable Charges
Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible • COE Facility • Non-COE Facility	 Medical Out-of-Pocket Maximum of $4,600 per individual, $9,200 per family No Out-of-Pocket Maximum
Organ Transplant Immunosuppressive Medications	See “Specialty Medications” below.
Organ Procurement Benefit	$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities Not subject to Deductible
Organ Transplant Transportation/Lodging	$10,000
BEHAVIORAL HEALTH BENEFITS	
Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).	
EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 EAP Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Prescription Drug Deductible per Calendar Year per Person	None
Participating Retail Pharmacy Copayment up to a 34-day supply:[1] • Generic Prescription • Preferred Brand Name Prescription • Non-Preferred Brand Name Prescription	 $25 $40[2] $50[2]
Non-Participating Retail Pharmacy Coinsurance	50%

Mail-Order Program Copayment up to a 90-day supply: • Generic Prescription • Preferred Brand Name Prescription • Non-Preferred Brand Name Prescription	 $50 $80[2] $100[2]
Specialty Medications[3]	10% Coinsurance, up to a maximum of $125 per prescription fill for a 34-day supply[4]
GLP-1 Medications for Obesity	50% Coinsurance; lifetime limit of 18 months; Prescription Drug Deductible does not apply
Calendar Year Prescription Drug Out-of-Pocket Maximum ("MOOP") (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Medical Expenses.**	 $4,600 $9,200

[1] For maintenance medications, only the original prescription and first two refills of maintenance medication may be purchased from the Retail Network. The third refill and all subsequent refills must be filled by the Mail-Order Program.

[2] Plus difference in cost between the generic and brand name prescriptions when a generic is available.

[3] Specialty medications that are included on the Select Drugs and Products List and are administered by a health care provider in a hospital, clinic, or facility, and those self-administered, are subject to Pre-certification for Medical Necessity and participation in the Select Drugs and Products Program. All Covered Persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to Prior Authorization, step therapy, and administrative review that may require specific drug distribution channels be used. Failure to obtain Medical Necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.

[4] Covered Persons who were receiving specialty medications prior to January 1, 2013 will continue to pay the Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable.

EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

Base Plan for Retired Employees Over Age 65 and Eligible for Medicare

Schedule of Benefits for Retired Employees and Eligible Dependents Over Age 65 and Eligible for Medicare with Base Plan Coverage

Effective January 1, 2024

DEATH BENEFITS – RETIRED EMPLOYEE ONLY	
Retired Employees' Death Benefit	$5,000
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Retirees and Eligible Dependents over age 65 that are Eligible for Medicare are covered under a Medicare Advantage Plan, which has its own Schedule of Benefits (see page 25).	
Hearing Aid Benefit • For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) • EPIC Hearing Service Plan	 $1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020) Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries
ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when an out-of-network non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.	
Organ Transplant Calendar Year Deductible Individual Deductible	 Major Medical Deductible of $600
Organ Transplant Coinsurance • COE Facility • PPO Non-COE Facility • Non-PPO Non-COE Facility	 90% of first $19,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges, Medical Out-of-Pocket Maximum applies 50% of Allowable Charges
Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible • COE Facility • Non-COE Facility	 Medical Out-of-Pocket Maximum of $4,600 per individual, $9,200 per family No Out-of-Pocket Maximum
Organ Transplant Immunosuppressive Medications	See "Specialty Medications" below.

Organ Procurement Benefit	$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities Not subject to Deductible
Organ Transplant Transportation/Lodging	$10,000
BEHAVIORAL HEALTH BENEFITS	
Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).	
EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 EAP Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Retirees and Eligible Dependents who are age 65 or over and Eligible for Medicare Parts A and B have a choice when electing Prescription Drug Benefits to complement the Medical Benefits provided through the **Medicare Advantage Plan**. Retirees and Eligible Dependents can choose the Base Plan's Prescription Drug Benefits or the Alternative Plan's Prescription Drug Benefits. The Alternative Plan's Prescription Drug Benefits provide a lower level of coverage at a reduced cost. Retirees who select the Alternative Plan's Prescription Drug Benefits will not have the option, at any time, of re-enrolling in the higher level of coverage under the Base Plan's Prescription Drug Benefits. Prescription drug coverage for both the Base Plan and Alternative Plan is provided through the **VibrantRx Employer PDP sponsored by NECA-IBEW** (VibrantRx), a group Medicare Part D prescription drug plan with additional coverage provided by NECA-IBEW. Please refer to the *Evidence of Coverage* from VibrantRx for details about the Medicare Part D portion of your coverage. **This chart shows the Base Plan's Prescription Drug Benefits.**	
Prescription Drug Deductible per Calendar Year per Person	$60
Copayment per prescription for up to a 34-day supply at a preferred network retail pharmacy: • Generic Drug • Brand Name Drug – Preferred Brand Name Drug – Non-Preferred Brand Name Drug	 $15 $20 $20
Copayment per prescription for up to a 60-day supply at a preferred network retail pharmacy:[1] • Generic Drug • Brand Name Drug – Preferred Brand Name Drug – Non-Preferred Brand Name Drug	 $30 $40 $40
Copayment per prescription for up to a 90-day supply at a preferred network retail pharmacy:[1] • Generic Drug • Brand Name Drug – Preferred Brand Name Drug – Non-Preferred Brand Name Drug	 $45 $40 $60

Copayment per prescription for up to a 34-day supply at a standard network retail pharmacy:[1]	
• Generic Drug	$15
• Brand Name Drug	
– Preferred Brand Name Drug	$20
– Non-Preferred Brand Name Drug	$20
Copayment per prescription for up to a 60-day supply at a standard network retail pharmacy:[1]	
• Generic Drug	$30
• Brand Name Drug	
– Preferred Brand Name Drug	$40
– Non-Preferred Brand Name Drug	$40
Copayment per prescription for up to a 90-day supply at a standard network retail pharmacy:[1]	
• Generic Drug	$45
• Brand Name Drug	
– Preferred Brand Name Drug	$60
– Non-Preferred Brand Name Drug	$60
Copayment per prescription for up to a 34-day supply at a long-term care facility:	
• Generic Drug	$15
• Brand Name Drug	
– Preferred Brand Name Drug	$20
– Non-Preferred Brand Name Drug	$20
Copayment per prescription for up to a 90-day supply through the network mail-order pharmacy:	
• Generic Drug	$25
• Brand Name Drug	
– Preferred Brand Name Drug	$35
– Non-Preferred Brand Name Drug	$35
High Cost or Specialty Medications	10% Coinsurance, up to a maximum of $125 per prescription fill for a 34- or 90-day supply[1]

[1] If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable. You may also prepay for your specialty medications and send proof of payment listing the prescription to the Fund Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.

DENTAL BENEFITS*	
Maximum Benefit per Person age 19 and older	$1,500 per Calendar Year
Maximum Benefit per Person under age 19	Unlimited
Coinsurance • Type I • Type II • Type III • Orthodontia	 90% of Allowable Charges 85% of Allowable Charges 50% of Allowable Charges 50% of Allowable Charges up to a lifetime maximum orthodontia benefit of $2,000
VISION BENEFITS*	
Coverage for each Covered Person age 19 and older includes:	Calendar year eye exam, lenses, frames, and contact lenses
Maximum Benefit per Calendar Year for each Covered Person age 19 and older	$400 maximum (up to $500 when using an EyeMed network provider)
Coverage for each Covered Person under age 19 includes:	Eye exams and materials related to vision correction, including any one of the following options: a. Frames and lenses b. Contact lenses c. One set of frames and a one-year supply of contact lenses
Maximum Benefit per Calendar Year for each Covered Person under age 19	No dollar maximum
EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

* If you wish, you may elect to cease coverage for dental benefits and/or vision benefits under the Plan for yourself or your Dependents. If you previously elected to cease coverage for dental and/or vision benefits under the Plan, you may reinstate coverage. If you wish to cease or reinstate coverage, you must notify the Fund Office in writing. See your SPD/Plan Document for more information.

Alternative Plan for Retired Employees Over Age 65 and Eligible for Medicare

Schedule of Benefits for Retired Employees and Eligible Dependents Over Age 65 and Eligible for Medicare with Alternative Plan Coverage

Effective January 1, 2024

DEATH BENEFITS – RETIRED EMPLOYEE ONLY	
Retired Employees' Death Benefit	$5,000
COMPREHENSIVE MAJOR MEDICAL BENEFITS	
Retirees and Eligible Dependents over age 65 that are Eligible for Medicare are covered under a Medicare Advantage Plan, which has its own Schedule of Benefits (see page 25).	
Hearing Aid Benefit • For Participants and Dependents age 18 and over (no maximum for Dependents under age 18) • EPIC Hearing Service Plan	 $1,250 per ear once every 5 years (not subject to Deductible or Coinsurance, and does not apply toward the Out-of-Pocket Maximum) (effective October 1, 2020) Access to discounts on hearing exams, hearing aid devices, and hearing aid batteries
ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when an out-of-network non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.	
Organ Transplant Calendar Year Deductible Individual Deductible	 Major Medical Deductible of $600
Organ Transplant Coinsurance • COE Facility • PPO Non-COE Facility • Non-PPO Non-COE Facility	 80% of first $15,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges, Medical Out-of-Pocket Maximum applies 50% of Allowable Charges
Organ Transplant Calendar Year Out-of-Pocket Maximum, after Deductible • COE Facility • Non-COE Facility	 Medical Out-of-Pocket Maximum of $4,600 per individual, $9,200 per family No Out-of-Pocket Maximum
Organ Transplant Immunosuppressive Medications	See "Specialty Medications" below.

Organ Procurement Benefit	$20,000 maximum (payable at 100%) at non-Centers of Excellence facilities; no maximum at Centers of Excellence facilities Not subject to Deductible
Organ Transplant Transportation/Lodging	$10,000
BEHAVIORAL HEALTH BENEFITS	
Behavioral Health Benefits apply toward the Comprehensive Major Medical Benefits Calendar Year Deductible and Out-of-Pocket Maximum. They are covered at the same Comprehensive Major Medical Benefits Network and Non-Network Coinsurance rates and are subject to the same Physician Office Visit Copayment. Behavioral Health Benefits include Mental Health and Substance Abuse services (both inpatient and outpatient).	
EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING AND REFERRAL PROGRAM	
3 Counseling Sessions	Plan pays 100%
PRESCRIPTION DRUG BENEFITS	
Retirees and Eligible Dependents who are age 65 or over and Eligible for Medicare Parts A and B have a choice when electing Prescription Drug Benefits to complement the Medical Benefits provided through the **Medicare Advantage Plan**. Retirees and Eligible Dependents can choose the Base Plan's Prescription Drug Benefits or the Alternative Plan's Prescription Drug Benefits. The Alternative Plan's Prescription Drug Benefits provide a lower level of coverage at a reduced cost. Retirees who select the Alternative Plan's Prescription Drug Benefits will not have the option, at any time, of re-enrolling in the higher level of coverage under the Base Plan's Prescription Drug Benefits. Prescription drug coverage for both the Base Plan and Alternative Plan is provided through the **VibrantRx Employer PDP sponsored by NECA-IBEW** (VibrantRx), a group Medicare Part D prescription drug plan with additional coverage provided by NECA-IBEW. Please refer to the *Evidence of Coverage* from VibrantRx for details about the Medicare Part D portion of your coverage. **This chart shows the Alternative Plan's Prescription Drug Benefits.**	
Prescription Drug Deductible per Calendar Year per Person	None
Copayment per prescription for up to a 34-day supply at a preferred network retail pharmacy:[1] • Generic Drug • Brand Name Drug – Preferred Brand Name Drug – Non-Preferred Brand Name Drug	 $25 $40 $50
Copayment per prescription for up to a 60-day supply at a preferred network retail pharmacy:[1] • Generic Drug • Brand Name Drug – Preferred Brand Name Drug – Non-Preferred Brand Name Drug	 $50 $80 $100
Copayment per prescription for up to a 90-day supply at a preferred network retail pharmacy: • Generic Drug • Brand Name Drug – Preferred Brand Name Drug – Non-Preferred Brand Name Drug	 $75 $120 $150

Copayment per prescription for up to a 34-day supply at a standard network retail pharmacy:[1]	
• Generic Drug	$25
• Brand Name Drug	
– Preferred Brand Name Drug	$40
– Non-Preferred Brand Name Drug	$50
Copayment per prescription for up to a 60-day supply at a standard network retail pharmacy:[1]	
• Generic Drug	$50
• Brand Name Drug	
– Preferred Brand Name Drug	$80
– Non-Preferred Brand Name Drug	$100
Copayment per prescription for up to a 90-day supply at a standard network retail pharmacy:[1]	
• Generic Drug	$75
• Brand Name Drug	
– Preferred Brand Name Drug	$120
– Non-Preferred Brand Name Drug	$150
Copayment per prescription for up to a 34-day supply at a long-term care facility:	
• Generic Drug	$25
• Brand Name Drug	
– Preferred Brand Name Drug	$40
– Non-Preferred Brand Name Drug	$50
Copayment per prescription for up to a 90-day supply through the network mail-order pharmacy:	
• Generic Drug	$50
• Brand Name Drug	
– Preferred Brand Name Drug	$80
– Non-Preferred Brand Name Drug	$100
High Cost or Specialty Medications	10% Coinsurance, up to a maximum of $125 per prescription fill for a 34- or 90-day supply[1]
[1] If you were receiving specialty medications prior to January 1, 2013, you will continue to pay the generic or brand name Copayments provided under the Retail Pharmacy Program or the Mail-Order Program, as applicable. You may also prepay for your specialty medications and send proof of payment listing the prescription to the Fund Office for reimbursement. You will be reimbursed under the Comprehensive Major Medical Benefit and will be subject to the scheduled Deductible and out-of-pocket limits.	
EXCLUDED PROVIDERS	
The Fund will not pay claims from the following out-of-network providers:	Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida

Medicare Advantage Plan

Schedule of Benefits for the Medicare Advantage Plan

Effective January 1, 2023

The Plan's Medicare Advantage Plan provides coverage for Eligible Retirees and/or Eligible Dependents who are Medicare eligible and enrolled in Medicare Parts A and B.

Humana.

MEDICAL	MEMBER PAYS
Deductible	$0
Medical Maximum Out-of-Pocket	$0
Primary Care Visit	$0 copay
Specialist Visit	$0 copay
Inpatient Services	$0 per admit
Outpatient Services	$0 copay
Inpatient Mental Health and Substance Abuse	$0 per admit
Outpatient Mental Health and Substance Abuse	$0 copay
Skilled Nursing Facility	$0, Days 1-100
Urgent Care	$0 copay
Emergency Care	$0 copay
Ambulance Services	$0
Durable Medical Equipment	$0
Routine Podiatry	$0 copay, 6 visits per year
Hearing	$0, Routine Hearing Exam- 1 per year $1,250 Allowance for each Hearing Aid – all types- up to 2 every 5 years. $2,500 total benefit.

Vision	$0, Routine Vision Exam- 1 per year
Fitness Benefit	Silver Sneakers Included
Foreign Travel Coverage	Member pays $100 deductible, 20% coinsurance, $25,000 Maximum Annual Benefit or 60 consecutive days, whichever is reached first. Limited to emergency Medicare covered services.

Prescription Drugs and certain other medical expenses (such as Organ Transplants) are covered under the Welfare Trust Fund, as shown in the applicable Schedule of Benefits.

EXCLUDED PROVIDERS

The Fund will not pay claims from the following out-of-network providers: Dr. Ahuva Gamliel and MiBaSo Holistic Health, both of Florida.

Service Providers

Effective September 1, 2025

SERVICE PROVIDER NAME	DESCRIPTION OF SERVICES PROVIDED	CONTACT INFORMATION	WEBSITE
IBEW-NECA Benefits Administration Association	Fund Office administrative services	800-765-4239	www.neca-ibew.org
BlueCross BlueShield of Illinois	Medical PPO network administration services	800-571-1043	www.bcbsil.com
Color Health	Cancer screening program services	844-352-6567	www.color.com/neca-ibew
EPIC Hearing	Hearing aid discount administration services	866-956-5400	www.epichearing.com
EyeMed	Vision provider network administration and claims services	866-800-5457	www.eyemed.com
Guardian	PPDO (dental) network administration services	888-600-9200	www.guardiananytime.com
The Hartford	Medicare Supplemental Insurance	N/A	N/A
Hello Heart	Heart health program services	800-767-3471	www.join.helloheart.com
Humana	Medicare Advantage Plan	800-733-9064	www.humana.com
MD Live	Virtual visits telemedicine and virtual mental and behavioral health program services	888-676-4204	www.mdlive.com/bcbsil
MedImpact	Prescription Benefit Management (PBM) services	888-807-5745 (TTY 711)	www.medimpact.com
Network Medical Review	Utilization Review and Medical Necessity review services	N/A	N/A
Optum Health	Centers of Excellence (COE) network administration services for transplants	800-847-2050	*Please contact the Fund Office for more information about COE services.
PaydHealth, LLC	Specialty drug program services	877-869-7772	www.paydhealth.com
Physicians Review Organization	Utilization Review and Medical Necessity review services	N/A	www.physiciansreview.org
Progyny	Fertility and family building program services	833-233-0952	www.progyny.com/benefits

RetireeFirst	Retiree benefit management service provider	855-433-1668 (TTY 711)	www.retireefirst.com
Sword Health	Virtual physical therapy and women's health program services	N/A	meet.swordhealth.com/necaibew/register
Telligen, Inc.	Wellness and disease management services; utilization review and case management services	833-226-7276	www.necaibew.totalwellbeinglife.com
TELUS Health	Employee Assistance Program (EAP) services	888-456-1324 888-732-9020 (en español) 800-999-3004 (TTY)	www.lifeworks.com
VibrantRx	Prescription Benefit Management (PBM) services for Medicare-Eligible retirees	844-826-3451 (TTY 711)	www.myvibrantrx.com/necaibew
Wex Health	Health Reimbursement Account (HRA) administration and system services	800-765-4239	www.necaibew.lh1ondemand.com